2005 Medical Plan Highlights

Note: This chart is a summary only. If the information differs from that of the official plan documents, the plan documents will govern. For details, contact the insurance carrier.

Covered Benefit	BC/BS PPO In-Network Blue Network P	BC/BS PPO Out-of-Network [1] Provider of Your Choice	Cigna HMO	HealthSpring HMO [2]	HealthSpring Alternative [2]
Deductible	None	$200 individual, $600 family. **Note:** deductible required for out-of-network care and services.	None	None	None
Coinsurance	Plan pays 80% of maximum allowable charges for most services	Plan pays 60% of maximum allowable charges for most services after deductible. You pay any amount over maximum allowable charge.	None	None	None
Annual out-of-pocket maximum	$1,000 individual, $2,000 family	$5,000 individual, $10,000 family	$1,000 individual, $2,000 family Note: Only mental health and substance abuse copays apply to out-of-pocket max	$2,000 individual, $4,000 family Note: Medical, surgical and behavioral health copays apply to out-of-pocket max	$2,000 individual, $4,000 family Note: Medical, surgical and behavioral health copays apply to out-of-pocket max
Hospital (semi-private room, supplies, drugs, routine X-rays, tests)	80% of maximum allowable charges	60% of maximum allowable charges	100%	100%	$250 copay each day for days 1 to 5
Emergency Room care	80% after $50 copay	60% of maximum allowable charges after $50 copay	$50 copay (life- or limb-threatening or if referred by PCP)	$50 copay (true emergency); must contact PCP next business day	$50 copay (true emergency); must contact PCP next business day
Surgery, office visits, anesthesia, consults, treatment, second surgical opinion	80% after $10 copay per visit	60% of maximum allowable charges after $10 copay per visit	100% after $10 copay per visit with PCP or specialist	100% after $10 copay with PCP and specialist	$200 copay for out-patient surgery
Maternity	80% of maximum allowable charges after $10 copay per visit	60% of maximum allowable charges after $10 copay per visit	$10 copay for first visit to confirm pregnancy; all later visits 100%	$10 copay for first OB visit; all later visits 100%	$10 copay for first OB visit; all later visits 100%
Prescription drugs	$10 copay for generics, $20 copay for brand names; certain drugs require pre-authorization; quantities of some drugs may be limited Maintenance drugs: 102-day supply for 2 copays (prescriptions must be on BCBST maintenance drug list); drugs not on the maintenance list limited to a 34-day supply at retail pharmacies Home Delivery Program (mail-order): 102-day supply for 2 copays	$10 copay for generics plus charges above usual costs; $20 copay for brand names plus charges above usual costs; certain drugs require pre-authorization; quantities of some drugs may be limited Maintenance drugs: 102-day supply for 2 copays (prescription must be on BCBST maintenance drug list); drugs not on the maintenance list limited to a 34-day supply at retail pharmacies	$10 copay for generic (30-day supply); $20 copay for brand name (30-day supply). If generic is available but you request brand name, you pay $20 copay plus difference between generic and brand name. Coverage for formulary drugs only unless pre-authorized. Mail-order program: 90-day supply for 3 copays (coverage for formulary drugs only)	$10 copay for generic, $20 copay for preferred brand name, $35 copay for non-preferred brand name (30-day supply) Mail order program: 90-day supply for 3 copays; maintenance medications only	$10 copay for generic, $20 copay for preferred brand name, $35 copay for non-preferred brand name (30-day supply) Mail order program: 90-day supply for 3 copays; maintenance medications only
Hospice care	80%; must be approved provider	60% of maximum allowable charges	100%	100%; $10,000 calendar year maximum benefit	100%; $10,000 calendar year maximum benefit
Home health visits	80% of maximum allowable charges	60% of maximum allowable charges	100%	100% after $10 copay per visit; up to 100 visits per calendar year	100% after $10 copay per visit; up to 100 visits per calendar year
Medical equipment (DME, wheel chairs, crutches, etc)	80% of maximum allowable charges	60% of maximum allowable charges	100%	80% of allowed charges, up to a combined benefit limit of $1,500 per calendar year	80% of allowed charges, up to a combined benefit limit of $1,500 per calendar year
Preventive physical exams	Not covered	Not covered	100% after $10 copay	100% after $10 copay per visit	100% after $10 copay per visit
Allergy injections	80% of maximum allowable charges after $10 copay for physician consultation	60% of maximum allowable charge after $10 copay for physician consultation	100% after $10 copay per visit or the actual charge, whichever is less	100% after $10 copay per visit	100% after $10 copay per visit
Well-baby care	Routine care until age 2; annual checkups through age 6 paid at 80% after $10 copay	Routine care until age 2; annual checkups through age 6 paid at 60% after $10 copay	100% after $10 copay per visit	100% after $10 copay per visit	100% after $10 copay per visit
Immunizations	Covered if required by public school guidelines through age 6; paid at 80% after $10 copay	Covered if required by public school guidelines through age 6; paid at 60% after $10 copay	$10 copay per visit	$10 copay per visit	$10 copay per visit
Vision and hearing tests (children under 17)	Not covered	Not covered	$10 copay; services by PCP	$10 copay for screening by PCP	$10 copay for screening by PCP

[1] Benefits for out-of-network services may be significantly less than in-network benefits. You will be responsible for coinsurance as well as amounts above the maximum allowable charges (as determined by BC/BST).

[2] You must live in one of the following Tennessee counties to enroll in HealthSpring (counties with asterisk have NO participating HealthSpring providers at the time of this printing): Bedford, Cannon, Cheatham, Coffee, Davidson, Dekalb, Dickson, Franklin*, Hickman, Humphreys*, Lawrence*, Lewis*, Macon, Marshall, Maury, Montgomery, Moore*, Robertson, Rutherford, Smith, Sumner, Stewart*, Trousdale, Warren, Wayne*, Williamson, Wilson. **NOTE: HealthSpring will update the list of counties as changes occur. Contact HealthSpring for the latest information.**

Covered Benefit	BC/BS PPO In-Network Blue Network P	BC/BS PPO Out-of-Network [1] Provider of Your Choice	Cigna HMO	HealthSpring HMO [2]	HealthSpring Alternative [2]
Skilled nursing facility	80%; 100-day maximum per person per year (must immediately follow 3-day hospital stay)	80%; 100-day maximum per person per year (must immediately follow 3-day hospital stay)	100%; 60-day maximum per person per year no deductible or copays	100%; up to 100 days per calendar year	100%; up to 100 days per calendar year
Radial keratotomy	80% (Lasik surgery not covered)	60% of maximum allowable charge; Lasik surgery not covered	Not covered	Not covered	Not covered
Custom-built shoes	80%, up to $1,500 lifetime maximum (includes repair and maintenance)	60%, up to a $1,500 lifetime maximum (includes repair and maintenance)	100%, up to $1,500 lifetime maximum (includes repair and maintenance)	80% of allowed charges, up to a combined benefit limit of $1,500 per calendar year. Benefit, annual replacement of shoes and/or inserts for diabetic members only.	80% of allowed charges, up to a combined benefit limit of $1,500 per calendar year. Benefit, annual replacement of shoes and/or inserts for diabetic members only.
Temporomandibular joint syndrome (TMJ)	Surgery covered as any other surgical procedure; 80% in-network; 50% non-surgical; $2,000 annual maximum; $4,000 lifetime maximum	Surgery covered as any other surgical procedure: 60% out-of-network; 50% non-surgical; $2,000 annual maximum; $4,000 lifetime maximum	$10 copay per visit for physician and facility charges, inpatient or outpatient; no coverage for appliances or orthodontia (braces)	100% after $10 copay per visit for physician and facility charges; maximum benefit of $2,000 per calendar year for authorized TMJ treatment	100% after $10 copay per visit for physician and facility charges; maximum benefit of $2,000 per calendar year for authorized TMJ treatment
Chiropractic services	50% of maximum allowable charge, up to $2,000 maximum per person per year	50% of maximum allowable charges, up to $2,000 maximum per person per year	100% after $20 copay per visit; PCP referral required; maximum of 90 combined chiropractic/physical therapy visits per year	100% after $10 copay per visit; no PCP referral required; 20 visits per calendar year	100% after $10 copay per visit; no PCP referral required; 20 visits per calendar year
Acupuncture	50% of maximum allowable charges; $1,000 maximum per person per year	50% of maximum allowable charges; $1,000 maximum per person per year	Not covered	Not covered	Not covered
Organ transplants	Special provisions apply to transplant coverage	Special provisions apply to transplant coverage	100% for most covered medical expenses and related services	100%; must be pre approved by HealthSpring	100%; must be pre-approved by HealthSpring
Physical therapy	80% of maximum allowable charges	60% of maximum allowable charges	100% after $20 copay per visit; maximum of 90 combined chiropractic/physical therapy visits per year	100% after $10 copay per visit; 30 visits per calendar year	100% after $10 copay per visit; 30 visits per calendar year
In-line-of-duty	Covered, subject to PPO and non-PPO provisions and copays	Covered, subject to PPO and non-PPO provisions and copays	Covered, subject to copays and HMO guidelines	Covered; subject to copays and HMO guidelines	Covered; subject to copays and HMO guidelines
Selection of physicians	Above benefits apply when you use in-network provider	Above benefits apply when you use out-of-network provider	All care must be received from PCP or PCP-referred specialist (women have open access to participating OB/GYN)	All care must be received from PCP or PCP-referred specialist	All care must be received from PCP or PCP-referred specialist
Non-routine lab/X-ray	80% of maximum allowable charges	60% of maximum allowable charges	Covered under office-visit copay	Covered under office-visit copay	$75 copay for MRI, CT scan, PET scan, and nuclear medicine
Mental health inpatient	80% of maximum allowable charges; pre-authorization required; maximum of 45 days per year	60% of maximum allowable charges; pre-authorization required; maximum of 45 days per year	100%; maximum of 30 days of combined mental health / substance abuse visits per year	100%; maximum of 30 days of combined mental health / substance abuse per calendar year	100%; maximum of 30 days of combined mental health / substance abuse per calendar year
Mental health outpatient	80% of maximum allowable charges; no pre-authorization required; 50-visit maximum per year combined with substance abuse	60% of maximum allowable charges; 50-visit maximum per year combined with substance abuse; no pre-authorization required	100% after $10 copay per visit; maximum of 25 visits per year	100% after $10 copay per visit; maximum of 30 visits combined mental health / substance abuse per calendar year	$250 copay for in-patient mental health; $10 copay for out-patient
Substance abuse inpatient	80% of maximum allowable charges; pre-authorization required; 1 admission per 90 days	60% of maximum allowable charges; 1 admission per 90 days; pre-authorization required	100% after $50 copay per day; maximum of 30 days of combined mental health / substance abuse visits per year	100%; maximum of 30 days of combined mental health/substance abuse per calendar year	100%; maximum of 30 days of combined mental health/substance abuse per calendar year
Substance abuse outpatient	80% of maximum allowable charges; no pre-authorization required; 50-visit maximum per year combined with mental health	60% of maximum allowable charges; no pre-authorization required; 50-visit maximum per year combined with mental health	100% after $15 copay for the first two visits; $25 copay thereafter, up to 20 visits maximum per year	100% after $10 copay per visit; maximum of 30 visits combined mental health / substance abuse per calendar year	100% after $10 copay per visit; maximum of 30 visits combined mental health / substance abuse per calendar year
Group therapy	Covered as mental health outpatient	Covered as mental health outpatient	100% after $15 copay per visit; maximum of 40 combined mental health / substance abuse visits per year	100% after $10 copay per visit; maximum of 30 visits combined mental health / substance abuse per calendar year	100% after $10 copay per visit; maximum of 30 visits combined mental health / substance abuse per calendar year

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